

REPORT OF THE INVESTIGATION OF THE CHILD WELFARE SYSTEM IN GREENE COUNTY, MISSOURI

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I. FOREWORD

This report is being submitted to the Honorable Bob Holden, Governor of the State of Missouri per his request of September 30, 2002. Governor Holden initiated the investigation in the wake of the tragic death of two-year-old Dominic James who was residing in a foster home in Willard, Missouri. Following the expression of concern by the Governor and an outcry for help by child advocates, this investigation was initiated. Principals in the development of the report were the Honorable Frank Conley, Richard C. Dunn, Patrick Lynn, and the Missouri Highway Patrol. The scope of the investigation was to review what had transpired in the James case and the child welfare system in Greene County as it pertains to foster care. The Missouri Highway Patrol was utilized in the interviewing of witnesses and a public hearing was held on November 12, 2002 for the general public.

While the tragic death of Dominic James led to the call for this investigation and the investigative team did review all records and took statements from the parties involved, the team has decided to leave it to the law enforcement officials and their ongoing criminal investigation to provide the public with their findings in that case. We found that the circumstances leading to Dominic James being placed and left in foster care was a manifestation of a broken child welfare system that requires immediate attention.

For use in this report, the child welfare system is made up of the juvenile courts, juvenile officers, social workers in the Department of Social Services' Division of Family Services (DFS), guardian ad litem (GALs), foster parents, law enforcement and the broader community (i.e., schools, family, emergency services, health care professionals).

II. COMMENTS FROM INTERVIEWS AND PUBLIC HEARING

There is a lack of public confidence in the child welfare system as evidenced by the following:

- A. The public has a great concern for the propensity of intrusiveness by DFS into the personal lives of both the natural and foster parents. This has evolved into distrust and a lack of confidence in agency personnel and the system as a whole.
- B. There was also testimony that there is an absence of sensitivity on the part of DFS and the courts for the feelings of natural parents, both personally as well as racially.
- C. In the course of the public meeting, witnesses frequently referred to "Gestapo tactics" on the part of DFS and the courts.
- D. Throughout the entire investigation individuals both inside and outside of DFS expressed an extreme lack of confidence in the agency.

- E. Paranoia was paramount in discussions with witnesses and in many instances biological parents, foster parents, and DFS workers expressed a fear of reprisals from DFS.
- F. Biological parents stated that they comply with a treatment plan prescribed by the planning team and that the rules and goals are changed and never ending thus resulting in their failure, and in some cases, termination of parental rights by the courts.
- G. DFS management seems to be out of touch with the needs of staff and the community and is believed to be biased and adversarial.

III. FINDINGS OF SYSTEM FAILURE

The child welfare system model being utilized in Greene County is dysfunctional as evidenced by the following:

- A. Morale is low throughout the Greene County child welfare system for children, their families and providers, as well as state workers.
- B. Greene County has a much greater number of parental right terminations as compared to the rest of the state particularly with infants.
- C. The Family Support Team is in many instances nonexistent. This is reflected in public statements and interviews made throughout the investigation as evidenced in the exhibits.
- D. Family Support Team meetings are not routinely held on a timely basis, and there is little positive dialogue between the parents, foster parents, GALs, DFS, school, and the court.
- E. Basic case planning decisions are made by the juvenile court, and frequently critical team members – juvenile officers, GALs and/or the Court Appointed Special Advocates are not available for team meetings on a timely basis. DFS social workers feel they have little input into case planning by the court.
- F. The child welfare system seems quick in some instances to remove children from natural parents without the benefit of adequate family support efforts.
- G. After the child is removed from the home there is little evidence of reunification efforts by DFS or the courts. Any reunification efforts that do occur appear to be complicated by the unrealistic expectations for parents by the court.

- H. The public repeatedly raised concerns about the difficulty of reunification when children are placed outside of Greene County due to the lack of foster homes, yet over 100 foster homes remain without placements in the county.
- I. Available treatment services for children and families are not incorporated in wrap around programs due to lack of funding and/or coordination.
- J. Social workers have excessive caseloads – sometimes in excess of 100 – that prevent them from performing home visits and ongoing supervision and planning.
- K. There is frequent turnover in social workers resulting in poor continuity of plans.
- L. Central office personnel are neither familiar with nor able to address the needs of the local offices.
- M. Leadership appears unable to adequately direct what needs to be a modern and effective delivery system.
- N. Examples of DFS action were found involving unilateral decisions being made relative to removal and placement outside of the state without court action and a failure to follow DFS guidelines and rules.
- O. The ability of DFS to follow through with basic and agreed upon treatment plans appears to be frequently compromised by Juvenile Court personnel.
- P. In some instances, rules were followed per DFS guidelines without use of common sense.
- Q. There appears to be a complete breakdown in dialogue with DFS, its workers, parents and constituents.
- R. Hotline calls appear to be handled haphazardly and at times are not followed up in a timely manner. On occasion, mandated reporter calls are not honored.
- S. Background checks of providers must be improved, including searching for out of state violations.
- T. Foster parents voiced little concern over reimbursement rates while a major reason for leaving the system was the lack of support from DFS.
- U. The foster home is rarely supervised closely and is provided with little background information on the physical and mental health of the child. In some cases this results in failure and frequent moves from one foster home to another.
- V. Few foster homes, if any, receive home visits, as evidenced in the James case.

IV. CONCLUSIONS

- A. Most DFS social workers appear to care for their clients, however due to caseload overload, lack of supervision and training, combined with a dysfunctional Family Support Team system the result is complete breakdown in the child welfare system.
- B. Parents and community members have no reasonable recourse to challenge actions of the system.
- C. The system is ineffective in allowing families a role in solving their own problems.
- D. The current background checks of providers are ineffective.
- E. There is a lack of training for DFS supervisors and social workers.
- F. There is a disconnect between the two major partners – DFS and the Juvenile Court – of the child welfare system in Greene County.

V. RECOMMENDATIONS

The child welfare system model being utilized in Greene County requires immediate attention in order to avoid a greater breakdown in services and serious problems.

Restore Public Confidence

- A. Create an Office of Ombudsman similar to that in the Division of Senior Services at the Department of Health & Senior Services.
- B. Create a citizens review panel similar to that outlined in 42 USC 5106a(c) to provide the public with a venue to air their grievances with the child welfare system.
- C. Evaluate the policy and procedures for background checks of providers.

Create an Effective Child Welfare System

- A. Review successful child welfare models of other states. Review the outcomes and techniques being used in the Missouri Alliance project.
- B. Create a community and court liaison program.
- C. Enhance training of all supervisory staff.

- D. Reduce caseloads of social workers to no more than 25 per worker, and for those with high acuity loads, no more than 12.
- E. Mandate that all children in foster care receive ongoing home visits, no less than that required in the DFS operational manual.
- F. Evaluate the ability of current personnel to develop new innovative programs, as well as deliver those programs that are required.
- G. Review the hotline effectiveness, both in processing calls and the follow-up of investigators per Missouri law and policy of the department.
- H. Immediately implement a program to assure children are safe in their homes and reduce the length of time children remain in foster care.